



902 North Orange St
Missoula, MT 59802
(406) 327-3300
Fax (406) 327-3302

~AUTHORIZATION FOR RELEASE OF INFORMATION~

Patient Number _____
(For Office Use Only)

Social Security Number _____ Telephone Number _____

I, _____, born on _____/_____/_____, hereby authorize:
Patient Last Name First Name Mo. Day Year

_____ Providence Surgery Center
_____ Other Provider (Please specify and include address/fax number)

to release medical information to:

_____ Providence Surgery Center
_____ Other Provider (Please specify and include address/fax number)

the following information regarding my care and or treatment on the following dates:

Please list specific information to be released (specific reports): _____

Purpose of Disclosure: _____

I understand and acknowledge that this authorization extends to all or any part of the information designated above, which may include treatment for physical and mental illness, and /or alcohol/drug abuse, and /or AIDS, and/or HIV results. I expressly consent to the release of information designated above. This consent is valid for 60 days, unless revoked by my written notice, provided written notice is received prior to the release of the above designated information.

X _____
Signature of Patient or Person Authorized to Consent Date

_____ X _____
Relationship to above, if not Patient Witness, required if patient unable to sign

If questions, please call Providence Surgery Center at (406) 327-3300. Fax number (406) 327-3302.